**NATIONAL ASSOCIATION OF LOCAL BOARDS OF HEALTH**
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**Concurrent Session: "Using Your Legal Powers: Success Stories from Boards of Health"**

**July 27, 2001, 10:45-12:00 am**

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| Moderator: | Maurice Mullet, MD, MPH, Health Commissioner, Holmes County Health Department, Ohio |
| Panel: | Marc Boutin, JD, Director of Governmental Relations, Massachusetts Chapter of the American Cancer Society |
| | David Brumagin, Member, Board of Health, Barberton, Ohio |
| | Glen Curtis, Member, Board of Health, Bear River, Utah |
| | Peter D. Jacobson, JD, MPH, Associate Professor, Department of Health Management and Policy, University of Michigan School of Public Health |
| Sponsors: | The National Association of Local Boards of Health and the Public Health Law Program, Centers for Disease Control and Prevention |

## PROCEEDINGS

Dr. Mullet

Welcome to this session which is entitled "Using Legal Powers, Success Stories from Boards of Health". We have a distinguished panel to address this issue today.

The legal authority of boards of health is really what sets then apart from others who do public health work. It's the authority and power that you as board of health members have that can really make something happen in your community as opposed to others who can suggest and lead and cajole with your legal powers. You can make things happen.

Peter Jacobson is going to give an overview of board of health authority and responsibility, Marc C. Boutin will discuss how to understand the full undue scope of a board of health's authority. David Brumagin will address board of health interaction with legislatures and then Glen Curtis will review the legal powers of public health departments in Utah.

To briefly introduce the speakers before we start:

- Peter Jacobson is an associate professor in the Department of Health Management and Policy at the University of Michigan School of Public Health. He received a law degree from the University of Pittsburgh School of Law, and a masters in Public Health from UCLA. Before coming to the University of Michigan, he was a senior behavioral scientist at RAND. At the University of Michigan, he teaches courses on the law of health care institutions and public health law. His current research interests focus on the relationships between law and health care delivery, public health policy, tobacco control policy, and violence prevention. In 1995, Peter received an investigator award in health policy research from the Robert Wood Johnson Foundation to examine the role of courts in shaping health care policy.

- Marc Boutin received his Bachelor of Science in Economics and International Politics Law from the University College of Wales and his J.D. degree from Suffolk University Law School. He practiced law for a number of years and then joined the Massachusetts Association of Health Boards where he worked very closely with all the elected and appointed boards of health in the Commonwealth of Massachusetts. He's been the Director of Public Affairs at Easter Seals; he's presently employed as the Director of Governmental Relations at the American Cancer Society. Marc is a faculty member at Tufts University where he lectures on health care policy, he is the author of a number of articles on regulating and forcing public health laws at the local level.

- David Brumagin's academic background includes a baccalaureate degree from Eastern Nazarene College, a Master of Divinity degree from Nazarene Theological Seminary, and a bachelor of science in secondary education from Kent State University. He was employed as a secondary school teacher, he's now retired from teaching but with two successful corneal transplants, he's been able to return to the classroom as a substitute teacher. He was elected to two terms on the Barberton, Ohio city council. During his ten years as a member of the city council, he served as a member of the Barberton Board of Health. He continues to serve as an appointed member of the Barberton Board of Health. David has served as a Trustee for the Ohio Association of Boards of Health and has provided distinguished leadership to our state association as President and now continues as immediate past President.

- Glen Curtis is a member and past chair, of the Bear River Board of Health in Utah which encompasses the three northern counties in Utah. He served as a county commissioner from 1983 to 1987. As a county commissioner, he was a member of the board of health and he's been serving since 1992 as an appointed member of that board. He is a past president and current legislative representative for the Utah Association of Local Boards of Health and in addition to his public health work, he is supervisor of industrial engineering for an aerospace company.

We will have a question and answer session at the end and Peter; we'll start with you. Thank you.

Mr. Jacobson

Thank you very much. It's a pleasure to be here. My materials include the full slides from a longer talk. I'm not going to make any attempt to go through them in their entirety, but they're available to you and please feel free, if you have any questions, to send me an email. My email address is pdj@umich.edu and I'll be happy to respond on any of the issues that I don't get to cover today.

Let me start by mentioning that my colleagues and I have just published a book called "Combating Teen Smoking, Research Policy Strategies" published by the University of Michigan Press which is intended for state and local policy makers who are implementing and interested in tobacco control programs for kids.

With that out of the way, I would like to say a few things about what I hope to do in my short time today. One is to give you an overview of your general legal authority and its limitations, particularly, some of the limitations that are not obvious and that I think are very important for local boards of health to understand in the current environment. Second, I want to convey the message that I view the law not only as the foundation of public health, but also as a mechanism for success. Law is a tool that can be used to develop and implement your programs and, particularly, to anticipate and prepare for the future. Third, it follows that this is much about rules of the road that should be followed. What are the rules that you have to follow to take a particular

action. Suppose, for instance, you want to stop, as we were discussing at breakfast, a potentially illegal landfill. What legal powers do you have? How do you go about it? How can you use your public health code successfully to achieve public health goals?

I also want to touch briefly on the importance of learning how to communicate with an attorney. It's not intuitively obvious how one communicates with a lawyer, no offense to my fellow members of the bar, but this is an important issue and something that I spend a fair amount of time discussing with my public health students. How do you effectively use an attorney? How do you get past the attorney's naturally ingrained and totally taught inclination to say "no"? Sort of like my children. They haven't progressed beyond the "no" stage.

Finally, I want to stress the interplay between law and politics. I think it's quite naïve to assume that we can use legal codes without understanding the political realities you face.

The first point to consider is the source of public health authority. I think the bottom line here is that you have an enormously broad grant of authority through the U.S. constitution and through state public health codes. Your authority is a function of state sovereignty delegated by the states to local your health departments and local boards of health. The seminal 1905 U.S. Supreme Court case of Jacobson vs. Massachusetts establishes your authority to act under a broad array of communicable disease and other situations. Law, primarily a state's public health code, is the underlying foundation for any action you want to take.

But you have to learn to use the codes. Some codes are very expansive. Michigan has a wonderful code. It couldn't be broader. It's almost impossible to imagine how this got through the legislature in the 1970's. It couldn't now. But I'm told that Colorado has a much narrower code and some states don't give you the breadth that Michigan has. So you've got to look very carefully at the provisions of your own state's code. What authority does it give you? What's the balance between state authority and local authority? What can you do on your own? What's required of the state? Has the state pre-empted any area? Tobacco control in Michigan is an example of state pre-emption. Genessee County was ready to issue tobacco regulations and the state said, "We don't think so. We're going to pre-empt this and take it for ourselves." So you have to understand that relationship.

The structure of your code is important. What authority do you have independently? As I said, the code just sets out the rules of the game. If you want to issue a regulation, what does the code say about that? What kind of notice do you have to give? Do you have to hold a hearing? Who has to be involved? How many days need to elapse between the announcement of the hearing? What's the process? It should all be spelled out in your local public health code.

How is your authority defined in the code? Are key terms even defined? In Michigan, for example, it's not even clear that all of the terms are defined but they're written in such a way as to convey almost complete authority for a local public health officer or a local board of health to define an emergency situation so that you can take action when you've got an outbreak of

disease. If you've got a contaminated product, if you've go mad cow disease in your jurisdiction, the code is where you go to define what you can do, what the limitations are, and what the sanctions are. One of the hard problems is defining which is the most appropriate sanction for any given problem. For example, do you want to try a civil remedy, a criminal remedy, or simply stop behavior? If you want to stop behavior, you may need to get an injunction.

Here is where your attorney is critical in helping you define what outcomes you want to achieve and what the best legal mechanism for achieving them is. Again, the question to ask the lawyer is, "Here is what I want to do. What's the best way to do it"? That makes it very hard for the attorney just to say no. Here he or she must think about what might work in a given situation. Most important, in my view, is that the code helps you to define solutions and anticipate problems. If you've got a concern, let's say, about bioterrorism, what does your code allow you to do to make plans and preparations?

What I use to pull all of this together is what I call, "The public health intervention matrix." On one side, I list the issues that you have to balance. What are the various concerns if you wanted to start, for example, a syringe-sharing program? You've got to be concerned about the abridgement of liberty and the potential criminal liability for your staff if there's a law prohibiting the distribution of drug paraphernalia. What are the public health benefits? Is the state interest compelling? What's the cost of the intervention? Then I move into some examples of activities that you might be dealing with. Tobacco is the most obvious issue and what I tried to do is to lay out the four domains that I think interact when you're making a decision. First, what's your justification for acting? That's important if you are ever taken to court because you want to be able to have your attorney lay out why the action is being taken, why you want to, let's say, limit the use of tobacco in public places. Second, what's the intervention? It gets back to what your remedy is, is the intervention an injunction? Is it a fine? Or, let's say to reduce selling tobacco to kids. Do you want to remove a license? What action do you want to take? If you've got a severe environmental problem, let's say PCBs are being dumped illegally, do you want to go for a criminal sanction? What are th implications of that? What are the legal issues here? The obvious legal issue that's going to permeate everything we do, I think, is the abridgement of individual freedom. Under what circumstances is it appropriate for the public health to be protected at the expense of individual liberty? That to me is the key question that keeps recurring. And finally, what is the political feasibility of the planned intervention? What can you do? What are the political obstacles that you face? How do you factor those into the public health intervention that you want to take? This is where I said the interplay between law and politics takes place. You may well have a strong justification for taking action, you may well have a clear intervention set forth in your code, but you may face political problems. How do you balance the two?

I'm going to skip over these next few slides to talk briefly about the future. Then I'll come back to some of the limitations that I think are very important in this environment. How can knowledge of the law, knowledge of the code, improve your program? I recently had the privilege of conducting a training session in Genesse County (Flint, Michigan) for the health

department staff. One of the things that was apparent was that the very high-quality staff had so much work that they didn't have time to focus on the code or time to understand it. A lot of what happened during the training was bringing out what the environmental health department did to use the code. That was useful for people looking at substance abuse or other communicable disease issues as illustrative of how to use the code to solve problems. The cross fertilization of bringing people together around the code, to understand what the authority was, was probably the most important and useful part of that training session. It helped them to ground their actions in the code and also gain a sense that just because they're often in different departments doesn't mean they don't face similar problems.

The other thing we did in that course was to use the public health code to anticipate future problems. One of the kinds of issues that public health officials ought to be looking at is genetic technologies. What areas, what issues, do we face with genetic technologies over the next few years that local public health agencies and local boards of health ought to be paying attention to? What kinds of interagency cooperation do you need to achieve public health goals? For example, I threw out the issue of substance abuse. Is it a public health problem? If it is, how do you think about it? How do you use the code to think through it? What other agencies are involved in this process? Youth violence is another one. Is it a public health issue? If so, back to the matrix, what's your intervention? Then there's the ever-present issue of public/private partnerships. The code should give you some guide as to what your authority is regarding outsourcing, contracting, etc.

There are lots of issues with that that we can explore in the question-and-answer period but there are, I think, three important limitations we need to think about over the next few years. The first is showing that the benefits of public health intervention exceed the costs. What we're seeing at the federal level is increasing attention to cost benefit analyses in regulatory policy. One thing the courts are starting to pay attention to is serious cost-benefit analyses in reviewing agency regulations. For another, in a more conservative presidential administration, you're going to have increasing pressure at the federal level to show that any particular regulation does not cost more than it provides benefits. Eventually, I think that's just going to filter down to the state and then to the local levels. So we might as well start thinking about it. As a limitation, it just forces you to define what the benefits are and to weigh the costs. No more lip service, as I did when I was in the federal government in the late 70's early 80's, when we sort of got out the back of the envelope, said "I don't think this really has much of an impact" and you could get that through. I don't think that's going to fly much longer.

The second limitation is a very complex legal issue known as the "takings jurisprudence". Under the Fifth Amendment to the constitution, if the government condemns private property, the state must compensate the owner of that property. For years that theory lay dormant because the doctrine of eminent domain provided a lot of authority. What's happening now, led by some academics and picked up by the U.S. Supreme Court, is that you now have to look at what are known as regulatory takings. For example, if you condemn a property to preserve it as a wetland, does that constitute a taking which requires just compensation as opposed to a legitimate

environmental regulation? It will be a serious limitation if the courts start imposing regulatory takings requirements.

Finally, some courts are starting to look more closely at your regulatory authority. There's one court in Ohio, for example, that struck down a tobacco regulation as going beyond the local health department's authority. I'm not suggesting that there's a serious trend, but boards of health need to recognize that there may be some limitations.

Just a couple of quick comments on my sense of the relationship between local public health activities and national issues. One is the notion of the shift from public to private. Whether one agrees with it or not, it is a fact of life and I suspect there'll be increasing pressure on you to think about public/private partnerships. The issue here, to me, is effective monitoring. Do you have in place systems to monitor the private system's performance? If not, you're simple ceding public health authority to the private sector without any opportunity to question whether the performance guarantees are being met.

The use of litigation to frame public policy is a separate topic, but there are times when I think you should be using the courts to change public policy. The lawsuits against the tobacco industry–even, though as noted this morning, the settlement funds haven't exactly been allocated to tobacco control–were still, in my view, a good idea of how to move the policy agenda. I wrote an article about the lack of a public health voice. We need to do a much better job on that. Finally, we in public health need to recognize that we are engaged in a collective endeavor in an age of rampant individualism. How do we think about that? How do we work through that? It seems to me that we've got to start asking what that means. How does that affect our legal authority? I will close with that. Thank you very much.

Mr. Boutin
Good Morning. I'm going to stand as well because when I sit down it's too hard for me to be a emotive with the hands. I'm French, I can't speak unless I've go my hands going. Let me start off with just a couple of quick questions. How many doctors are here today? Any doctors? A medical doctor. Okay, we have one. How many lawyers? We have one? Okay, great. how many people here have had legal training on their own board of health authority? A couple of you, okay, good, great. How many people here like Cajun food? Okay, then you need to go to a restaurant called "The Fat Fish Blues". It's fantastic, about a 10-minute walk. The reason I asked you the first set of questions is with respect to lawyers, I'm always curious as to whether or not there are lawyers in the audience. With all due respect to my colleagues, lawyers tend to be the most difficult people to explain law to. And so I kind of bear that in mind and that's because often times, they have a good, solid understanding of it but a lot of times we end up conflicting in terms of our own perceptions and thoughts on it.

**I want to start off just talking about authority in general and give you my perspective on public health authority at the local level and then I want to talk to you about a number of individual rights. Peter mentioned this just briefly before. But they're the rights that often**

**come up at the local level and they come up in a very obnoxious way. It's the sort of situation where you have somebody who's not happy with what the board of health is doing. They hire an attorney for a day and the attorney will come into your office and beat on the table and tell you you don't have the authority to do what you're doing. They'll list off a few legal terms, what have you, and you become intimidated if you are not an attorney. And often times, they have the ability to redirect where the board of health is going. So I want to debunk a couple of those issues that arise at the local level.**

**But first let me talk about authority. You had a great explanation of board of health authority just a couple minutes ago but I want to give you my perspective, as well. First of all, in my view, the best way to look at this is to start right at the very beginning. The federal constitution gives the federal government what's called "enumerated rights" or "enumerated powers". "Enumerated", means that the federal government can do whatever is listed for it in the federal constitution. For example, the federal government can raise taxes. The federal government can have an army. The federal government can defend itself. It can regulate interstate commerce. State governments are given what's called "plenary powers". Plenary powers are very expensive. States, unlike the federal government, can do whatever they want so long as the constitution does not prohibit them from doing it. For example, states may also raise taxes. States can set up police departments to protect their citizens. States cannot do those things which are listed in the constitution that they're directly told they cannot do. For example, states cannot regulate interstate commerce. States cannot engage in treaty making with other countries. States cannot raise armies. States can do whatever they want so long as they're not told that they cannot do it.**

**States, in turn, have delegated public health authority to local health departments and originally, boards of health were given wide latitude in authority. They were given what was called "plenary powers". Boards of health were originally told that they could regulate all public health matters at the local level. Over the years, that authority has been eroded and restricted and today, we have a real wide range of authorities across the country for boards of health. Massachusetts has perhaps one of the most broad grants of authority. In Massachusetts, the authority is so broad that you start off with the presumption that the board of health's actions and regulations are presumed valid. So that's a presumption in favor of the validity of the board of health action in Massachusetts.**

**There's no right to an individual appeal in Massachusetts. If an individual is unhappy with what the board of health does he or she can't even appeal it. All they can do is ask a court to review the record. And in reviewing the record, the burden is incredibly high and it's on the person challenging the board of health. They have to show the absence of any conceivable ground upon which the rule or action may be upheld. You compare that with some other states where the board of health is required to go to court before it may take any action or issue or a regulation. So we have extreme variations in the authorities of boards of health. In some states, the authority has been eroded to the point where the**

**board of health cannot take any action without first going to court and getting a court order. Yet we have the example in Massachusetts where boards of health can essentially do anything they want as long as there is some basis in public health.**
**This means that you need to know exactly where your authority is for your individual state. It's difficult for us on this panel to tell you exactly what your authority is because I'm sure we have a number of states represented here. So your homework, if you have not already done it, is to go back and figure out exactly where your authority is between the two extremes, from the very broad to a much more narrow basis of authority.**

**Let me talk about some of the asserted individual rights that have an impact on what you do at the local level. These assertions often seriously overstate actual legal individual rights. How many people here have had the situation where somebody has been unhappy with what the board of health is doing and they've hired an attorney to come to your board of health hearing? Looks like about half of you. In Massachusetts at least, this has been a very common practice. In Massachusetts, I've attended over three hundred board of health hearings that have ranged from tobacco control to needle exchange to putting fluoride in the water, regulating septic systems-- many instances where an individual has hired an attorney, often to come and beat up on the board of health. The issues raised are often property rights, due process and equal protection and privacy. And often they're raised in a manner that makes me wonder if the attorney has any idea what he or she is talking about. Let me describe some of these rights quickly for you.**

**In property rights as you heard before, there's something called "the takings clause" which says the government cannot come in and take your property without first paying for that property. But there's a wide range in the way that clause is interpreted vis-a-vis boards of health. In Massachusetts again, with a very broad grant of authority, the board of health may put all kinds of limitations on property. You could require that it be utilized in certain ways, put restrictions on the property, order repairs, order an alteration to a property, or simply demolish a building. In Massachusetts, the board of health has the authority to level a home without ever having going to court. They can simply demolish a building. There's procedural requirements that they have to adhere to but the board of health can actually demolish a home. And then put a lien on the property for the cost of demolition. In Massachusetts, one of the board's powers is that you can actually take the property or order restrictions or repairs or alterations, there's no need to pay for that, even if you demolish the building. In Massachusetts, there's an explicit grant of authority to the board of health which says that the board of health may take this property or demolish it and not pay for it. The principle in Massachusetts is that if the property is in violation of public health, it has no value and as a result of that lack of value, you can actually demolish the building and not have to pay for it. In many other states, the board of health, like other state entities, has to pay for any property it taxes. And you may or may not have the money in your budget to actually do that. So again, you need to know where your state sits on this particular issue. But by and large, you have the ability to interfere in personal property right to a large extent because of your public health "police powers".**

**With respect to due process, due process is one of those terms that lawyers like to throw around because it sounds good. We see it in the movies; we see it on the TV show "The Practice". But what does it really mean? With boards of health, the primary issue with due process is that there are procedural requirements for certain activities that you must adhere to. They're written in your codes and in your state laws. The one due process requirement that I sometimes see boards of health get hung up on is this. If the board gives an individual or an organization any sort of benefit, for example, a permit to collect trash or a license to sell tobacco, and if, as a penalty, you want to take that license away, either through a suspension or a revocation process, you must afford the individual the right and opportunity to be heard. You need to give them a hearing before you take that license away unless it's an emergency situation. If it's an emergency situation, you can generally give a hearing after the fact. But by and large if you give a license or a permit, you must afford the individual the opportunity to be heard. That's the area of due process where boards of health sometimes go awry. Beyond that, due process is a term that is thrown out in a way to intimidate boards of health but it doesn't have a tremendous amount of meaning unless it's going directly towards the procedural requirements of affording a hearing.**

**On equal protection: How many people have had an attorney come before their board of health and say "This is an equal protection violation, you can't do it"? Equate protection often comes out this way: My neighbor Joe Shmoe has a bunch of trash in his yard and I happen to have a bunch of cars in my yard leaking oil. The board of health comes out and says, "You've got to get rid of those cars, you've got to clean up the mess". The neighbor says "But you didn't make Joe Shmoe clean up the trash in his yard, I'm not going to do it". Board says, "Yes, you are". The neighbor says, "No, I'm not. I demand equal protection. You're got to treat me the same way you treated him. You didn't order him to clean up the junk in his yard, you can't do it to me." The board of health my start to think "Well, you know what, we didn't treat them the same, maybe we can't do it". Is this correct? Absolutely not. Equal protection deals with protected classes. You must treat people in protected classes the same. Protected classes are race, religion, disability. They need to be treated equally. You cannot discriminate against an individual because of the color of their skin. Does not mean that you have to treat all individuals the same. You, as a board of health, may take into consideration the factors of the individual case. Equal protection prohibits discrimination against protected classes. Equal protection is often thrown out against the board of health as a justification not to take action because you did not take action in other circumstances that may have appeared to be similar.**

**The last one I want to talk about is the right of privacy. We as individuals have a right of privacy. The state or the government cannot come into our individual homes without search warrants. For example, the police, if they are looking for drugs, need to have a search warrant to enter your home to look for those drugs. Let's suppose that you as the board of health need to go in and conduct an inspection. Maybe you're on notice that**

**there's a violation of the state sanitary code. And you want to go in and conduct an investigation. Do you need a search warrant? By and large, it's going to depend on your state code. Many codes require search warrants but there are two fundamental principles that you can keep in the back of your mind. The first is, search warrants are generally not required if there is not going to be a threat of criminal prosecution. By and large, much of what we do in local public health is to insure compliance with certain mandates. Compliance with certain mandates does not mean that you're going in to do an investigation for a criminal prosecution. There can be some exceptions. One exception that comes up is when there is toxic waste. In many states, waste dumping is a criminal violation. And your investigation may ultimately lead to a criminal court case against an individual or an organization. But by and large, much of what you do will not be a criminal investigation and, as a result, you do not need to get a search warrant similar to what police get. In many cases, however, under your state codes, you are required to get administrative search warrants. And administrative search warrants are not held at the same level as criminal search warrants. You do not have to show probable cause that a violation exists with administrative search warrants; you just need to show that you are trying to insure compliance with public health rules and regulations. There's a much lighter burden for a board of health to request an administrative search warrant as opposed to the police going to a court to request a criminal warrant. The other piece to keep in mind with most warrants, even the administrative warrants that you may be required to obtain under state codes, is that if you receive consent from the individual, you do not have to get a warrant. For example, if you want to conduct an inspection of a restaurant, you go in, and you advise the individual you're about to conduct an investigation. If the person says "fine", you have consent. There's no need to go to court to get a search warrant. Consent is the easiest way to obviate the need for an administrative search warrant in almost all jurisdictions.**

**The last thing I want to say is, and you guys already know this because of the great work that you are doing at the local level, that you need to achieve a balance between your own legal authority and the individual rights of the people that you're serving. As Peter said earlier, you have to deal with politics. You guys, whether you like it or not are local politicians and that, in my view is perhaps the most difficult issue that you face. Your legal authority is something that you can learn quite easily, and you can use it as tool to accomplish what you need to do at the local level in terms of public health. Politics is much more of an art form, and requires quite a bit of time and energy in order to manage. With an understanding of politics you can balance your authority in a way that you can make meaningful and successful interventions in public health at the local level. The politics, I think, are much more of an impediment for most boards of health than are the law or laws that you must follow. And that's it! I look forward to your questions.**

**<u>Mr. Brumagin</u>**

**Good morning, everyone, and welcome to Ohio. I want to start out by talking about the**

**role of instinct in public health. Here's a little story.**

**Mother Skunk had two offspring, and knowing her offspring like she did, she named them In and Out. Whenever In was in, Out was out, and when Out was in, In was out. Never were they in together unless it was for mealtime, or naptime, or to go to bed. One day Out was in and In was out, and Mother Skunk looked at Out and said "Out, go out and bring In in – it's time for lunch." And so Out went out and came right back with In, and Mother Skunk was impressed. "My, Out, you did a great job! How in the world did you get In in so quickly?" Out looked at his mother and said "Mom, it's easy. In stink!"**

**City government, Barberton, Ohio, being no exception, does so much by instinct, and they end up stinking. Imagine yourself sitting at a desk. You're doing your job, you're shuffling your papers, you're answering the phone, you're acknowledging everyone who comes in. And on the front of your desk it reads "Health Commissioner". And you receive a communiqué "You've been fired by the Mayor." Well, it's kind of an interesting situation. Can a Mayor fire you? Well that happened in Barberton. We had one mayor who decided, boy, I'm going to take over the health department. And he fired the Health Commissioner.**

**Then you've got those guys that dream up the budget for the city, and they came down and said "Oh, we're giving you, the health district, the money, therefore we can tell you what to do!" Surprise! The Ohio revised code, clearly makes the health district an independent entity. You have to know what your code is for your state and know it well. You don't know how many times in Barberton–in fact, every time we get a turnover on the City Council--have to sit down and re-educate them. And simply point out "Hey, look, it is your obligation to support us. It is not your obligation to run us. We are a separate entity underneath the state. We function independently."**

**But it is really part of your obligation to make sure that your elected officials understand how they're to support you, and to make sure that they understand that you have your obligations to the community and that you are directed by your state health department, if that's the way that you are set up to do it.**

**In Ohio we have an open records law, and while I was on city council we literally tape recorded all of our sessions and meetings. Simply because anybody could walk in and say "Hey what did you discuss? I want to hear that tape." And we taped all of our regularly meetings, and those tapes are kept on file because a person can walk in and say "Hey, I can read the minutes, but what was said that didn't get into the minutes?" You need to protect yourself in terms of what you're doing and saying in meetings so that if there is any question that ever arises, you have some sort of legal protection.**

**You know, the closest I ever got to being a lawyer was when I walked down Olivero Street in Los Angeles, and I took out $2, you know. Put it down in front of a lady, wrote my name**

**down. You know they have all these nice little people that come out and tell your fortune or whatever. I put the $2 down, and wrote my name down, and she said "Huh, you're a lawyer, or you're going to be a lawyer." Boy did I panic. It's bad enough teaching English, and wondering why people split infinitives and use "myself" instead of "I" or "me".**

**As a board member, make sure you understand the legal ramifications of your job. While I was on city council and even now as a health board member, I have friends who are lawyers. Whenever a question arises that I don't have the idea where to go, I not only call one, but I call two or three because legal opinions are legal opinions, and that's it. Make sure your health board has a handy lawyer. I thank God we've got an attorney as our health commissioner. Saves all of that worry. But his opinion is only his opinion. But nevertheless, having a lawyer there on the health board is extremely important.**

**Let me leave you with one more thought. Come to our pancake breakfast some day around Labor Day down at Lake Anna. I understand that last year Father Mole stuck his head up out of the hole across from where we have our pancake breakfast, and he says "I smell pancakes! And I see people lined up." Mother Mole stuck her head by his, up through there. Looked over. (Sniff, Sniff) "I smell that ham! Oh, that's good!" Baby Mole down in the hole got carried away. So he tried to wedge his way up, wedge his way up, wedge his way up – couldn't quite make it up to the top of the hole. They went back into a family conference, and Mother looked at her baby and said "Did you smell that ham?" And the father looked at him, "Did you smell those pancakes?" He said "Noooo, I smell molasses!"**

**I've enjoyed the discussions, and learned a lot!**

**Which reminds a little bit, by the way, of a story that I heard in our home town in small town of Treemont where the pastor and a health officer and member of the board of health were golfing together, and actually were just trying to golf because they had waited an extensive period of time for a threesome in front of them that was just taking forever. And the board member said "This is terrible. I've never had to wait so long. We've must have been here fifteen minutes." The health officer says "I've never seen such ineptitude. What's wrong with those guys?" And the pastor says "Maybe we ought to ask the groundskeeper what's going on – let's have a discussion with him" So they went "George, come over here" and said "We've been waiting over fifteen minutes, and that group of golfers is there forever. What is the problem?" The groundskeeper said "You know, that's the group of firefighters that fought the club house fire when it was burning to the ground, and they saved the club house and lost their sight. They're all three blind. But out of gratitude for their service to the club, we've allowed them to golf any time they want to for free." The group fell silent for a moment, and the pastor said "That really is sad. I think I will say a special prayer for them this evening". And the health officer said "You know I have an ophthamologist friend. I'm going to call him as soon as we're through, and see if he can do something for them." And the member of the board of health said after thinking for a moment "Why can't they golf at night?"**

**Mr. Curtis**

**Good morning. Let me give you just a little bit of background about Utah public health, which fits somewhat with the previous presentations. Utah code Chapter 26-A is very specific. In fact at a recent NALBOH conference, Utah was identified as having a model for how health departments can be organized and structured. It's relatively specific in granting boards true authority. It gives the authority to the county commissions to appoint, define, and establish boards of health. It gives counties the authority to set up single or multi-county boards. In Utah we have twelve health districts. Six are multi-county and six are single-county. There's some financial incentives to being multi-county in terms of funding formulas. The boards are relatively independent. The county commissions have the authority to appoint board members to five-year terms. Throughout Utah county commissioners serve as members of the board of health along with the appointed members.**
**The boards have some pretty specific authorities, including establishing policy, holding hearings issuing rules, and setting fees. They also hire and fire the health director and handle the grievances within the department. Within our state every health department has customized the laws to actually address their own priorities. A couple of the issues that are significant, is that while the funding formula typically is mandated by the state, less than 5% of the funding of local departments in Utah is provided from the state general funds, 11% is by defined contracts from the state including federal funds, 37% come from fees, and 47% from county contributions. We don't have the ability Ohio has to just write out the bill. The county commissions decide how much to give us. That is one of the two key controls the counties have: the ability to appoint board members, and the ability to decide how much to fund their local departments. And as you might expect, funding is inequitable in various places in the state.**

**One of the concerns for both departments and boards is that the fees are growing fairly quickly as the other funding sources fail to keep pace, and the fear that at some point we are counter- productive in terms of our fees. One of the things that frustrates us substantially is the fact that only 9% of the state department's money goes to local Public Health after your takeout Medicaid. If you leave Medicaid in, it's about 1%. Graphically, over the last five years you can see that contributions from counties are growing, fees are growing faster, and the state contributions are fairly flat.**

**Just a couple of other challenges that I'll briefly address in terms of what we're trying to do or been trying to do is the state department of health seems to evolve away from being a partner of local health departments. Instead of being partners, there are conflicts over authority, over funding, over responsibilities, and only a very limited amount of coordination. We also have the challenge that some of the key officials in our state, including the head of the department of health, and the governor, really think that public health means adequate health insurance. Both are insurance executives without the public**

**health background. Both are very committed to doing what they believe is right which means assuring that everyone has access to public health. We've had some significant issues over the last few years, particularly in the urban counties, of conflicts between commissioners and their boards – in terms of authority.**

**We've had a problem also come up frequently in terms of lack of a good public image. What is public health? It's hard to go to the legislature and talk about preventative services. And finally, Utah, some of you may have heard, is a somewhat conservative state, and we have a number of issues that create additional conflict. For example, battles over fluoride, indoor air, and seat belt laws. We have felt like we have had a real lack of a statewide presence, a statewide voice. This point hit me hard one year at our state symposium where we regularly pass resolutions. It occurred to me that we typically do a great job or writing or passing them, but I'm not sure they make it a whole lot beyond that. We have relied more recently on the Utah association of local boards of health, and we work closely with the state association of health officers who generally meet with us. We have a full-time executive that both associations share and we have attempted to improve coordination. I believe we've made some progress in part because we're doing a better job of speaking with one voice. Associated with that is the ongoing need to educate legislators. As we prepared these issue papers, we've made the effort to sit down with legislators, the Speaker of the House, and the Senate President. We've spent time with the local legislators on key committees and with local people taking the resolutions that represent all of the state boards of health and all the health officers. We've had a fair amount of success. We've also found success as we invite in local legislators and spend time reviewing the funding formulas and helping them recognize the disparity of the funding formulas.**

**Despite the fact that we have what I believe is a fairly clear-cut law, Utah Code 26-A, that says what we do, there is frequent and regular disagreement over what it really says. So we've put together a packet, and said "Here's what the law says, and you can read it and it ought to be pretty clear, and here are how the health districts are organized and here's what the key issues are." And as we sit down with various legislators, we use that as a tool to help them understand. It was one of those discussions, a discussion with the governor, that helped us understand how far off we were when he was frantic with someone who as an appointed body had final authority to spend money, and we recognized we have a fair amount of way to go. We also share that information with the county commissioners and their state association.**

**I mentioned 9% of the state funding, and that has been a source of irritation to us at least for the last 15 years. Fifteen or sixteen years ago we had a major battle between county commissioners in reallocating the funds we had. When we got done we found out that we were killing each other over less than 1% of the money that was spent on public health, and said there was a serious problem with that. The members of the legislature are typically in tune, because they are local, with our concerns and frustrations. We believe the state overall is getting a lot of money, and so we're not particularly willing to give more money,**

**and in fact, in years where they attempt to pass more money through the state department, we don't get a whole lot more anyway. We have attempted over the last three years to create a separate funding source for local departments, and in the last year, we've been able to work with the analyst to the legislature who saw that made a lot of sense and then created a separate line item in the state department of health budget that simply flows money through. We now have a mechanism that if we work with legislators we can put money in that line, and hopefully it will come through unscathed to local departments. We'll see how well that works.**

**Another area where Utah has seen some good success is in our tobacco reduction program, "Second Hand Smoke". One of the challenges that Utah has is that tobacco is viewed by many as a religious issue, and that tobacco control programs are an attempt to impose on the values of religious groups. We've worked hard over the last decade to emphasize that this really a health issue. It's taken many years in the campaign with many organizations to make a difference. I think while boards of health have been real strong supporters, it has actually been other groups who are rabidly involved and committed to these concepts that have really made it successful. If anything, I feel guilty we haven't done more, but together we have been strong supporters of those objectives and have strong laws in terms of indoor smoke. There are strong limits on smoking in the state of Utah. Smoking is banned in almost all public buildings. At the same time, we have fought to raise taxes on cigarettes, hoping that would make a difference both by limiting access as well as by increasing funds for public health. We've been unsuccessful at that because our legislature made promises never to raise taxes. But the following year they needed some money for roads and they raised taxes on tobacco. So it just depends on what the money is used for, and at least half of our objective was achieved whether the money was spent for roads for new programs to help stop or limit tobacco use.**

**We have another exciting issue with fluoride. In Utah, only 3% of the population has fluoride in the water compared to 66% nationally. It's a huge issue. One of the two cities in the state that has fluoride is the city I grew up in and is in my district. After fluoridation was allowed in 1966 or so, the legislature passed laws making it almost impossible to add fluoride anyplace else. Over the last five years, Salt Lake County has passed legislation to allow that county to vote countywide by district, which led to adoption of fluoridation. But most of the members of the board of health were not re-appointed, in part because of their battle for fluoride. Two other counties had fluoridation on the ballots and succeeded. Within that county two cities are signing petitions to make fluoridation a statewide issue because of individual rights, communist plots, and all the things we've learned about fluoride being so terrible for us on the Internet. It's an issue that we are continuing to work on and are slowly making progress.**

**And finally, one of the big frustrations that I feel over the last few years is that we in public health have become more embattled with many of the people who should be our partners. In part by our own outspoken commitment to our autonomy we have gained authority in**

**part by a turnover of county commissioners who recognize they have a responsibility for budget funding. We have reached, in some areas, fairly strong conflicts. A couple of boards of health have been restructured in part because county commissioners wanted to clarify their responsibilities and authority. At best this detracts from our mission. At worst it takes away funding since county commissions in our state still control the level of funding. It certainly removes or has the potential to remove people from the boards that are very dedicated. We've had issues where again it's clear in our mind that we set fees, but the state department of health and the local departments of health believe they are exempt from any fees that we set, and the Attorney General's office has stood firmly on both sides. And so we recognize that if we're battling one another we're not really moving forward. It's important, regardless of what the law says, that we bring along partners and we work together so we don't become embattled rather than attempt to succeed in our public health mission. Thank you very much.**

**Dr. Mullet**

**Now if the panel will take seats here at the table, everyone will now have an opportunity to participate in the discussion. There is a microphone in the aisle about mid-way back. We ask you to use the microphone to ask your questions. While we're getting our first person to ask a question, let me mention that we are in the Dorothy Fuldheim Room. Dorothy Fuldheim was a news commentator in a local TV station here who we thought would live forever, and she almost did. She was one of those pioneers who literally was able to bring in anyone, put them on the spot, and create an interesting interview. Being in this room brought back fond memories of some of the great interviews she did with people like Hubert Humphrey. You go down the list and she interviewed them. She was an outstanding person, so when you return home from this conference you can talk about the fact that she was one of those pioneer women interviewers who just was absolutely great.**

**Question**

**My question is, if am I correct, one of your slides said that legislators are invited to district health officer meetings on a quarterly basis, do the district health officers have the opportunity to what we say "lobby" because in Georgia it's strictly against the law for health officers to do something like that.**

**Answer – Mr. Curtis**

**You're correct, they are invited to their meetings, and I believe they're educational. They have lunch, and they're two-day meetings – they'll invite a legislator or two or three from critical committees, sit down and have lunch, and then just talk about what the local issues are. They're visiting that part of the state, so they discuss local issues but the statewide concerns are being expressed, too.**

**Answer – Mr. Boutin**

**Let me address that, too. I'm a lobbyist for the American Cancer Society. I direct their government relations. In some states there are explicit exemptions for boards of health and their staff to lobby. Massachusetts is one of those states where almost everybody who lobbies has to be a registered lobbyist including myself. One of the clearest exceptions is that health departments and their staff may actually go in and lobby by actually asking for specific legislation or appropriations without having to register as lobbyists. So it depends on your state's laws where states have prohibitions on lobbying education is a very valid component. If you are providing education in terms of describing the services you provide, what your needs are, what you want to happen in terms of local public health, that is okay as long as you're not making a specific request for a particular policy or legislative initiative or appropriation. So there is a fine line where you can actually meet with your legislators even in those communities where lobby, as such, is prohibited.**

**Question**

**Yes, I believe one of the speakers said it is very important to tape meetings and to keep those tapes. One of the issues that I find, not only in boards of health but also in township council meetings, is sometimes when you review those minutes they condense a two hour discussion into two sentences. I was wondering was there was some discussion of legal ramifications. Is the decision to tape the entire meeting based on the assumption that somebody can later come in and say "Well I think I heard this, this and this, and the minutes did not reflect any substantial issues and so the board or council may be liable?"**

**Answer – Mr. Brumagin**

**That's exactly right. In Ohio we have an open records law which states that everything we do and say in a given meeting has to be kept for review. How it affected us on the city council was that the three of us couldn't sit down in a booth and have coffee and discuss an issue. We had to do it in a committee room with a tape running so that there was an actual record that could be referred to. It really has never been challenged much as far as I'm aware of. We've not had any problems in Barberton, but nevertheless it's handy and it makes me feel more secure. I would like to defer to Joe Harrison for any additional comments he may want to make on that open records law, and the taping because we do it frequently.**

**Dr. Harrison (Barberton, Ohio Health Director)**

**I said taping is usually a good idea, but you should be sure you don't say the wrong thing on the tape.**

**While I'm here I have a question, myself. Do any of the panelists feel that a board of health should be required to have an attorney on staff to advise the board?**

**Mr. Boutin**

**That's a great question. One of the things I've always said to boards throughout Massachusetts is that the best make-up for a board of health in Massachusetts is to have somebody with a medical background, somebody with a legal background, somebody with an engineering background because we have a lot of septic systems, and then also somebody who has common sense. Because unfortunately the doctors, lawyers and engineers go to school and a lot of times that is pulled away from them. You need somebody from the local community that just knows the community. When you can have all those in one spot, you usually have a really balanced, well-educated board of health that can achieve a lot of different things. To require that make-up might be difficult just because it's hard to find lawyers that are knowledgeable or interested in public health, quite frankly. But having them is great.**

**Mr. Curtis**

**But that is a critical point. Not having just a lawyer, but having a lawyer with a background in public health law who understands the code or who gets training in public health law. One of the problems I've heard from many of your peers, and from local health officers, is that even when they have access to an attorney, that attorney is fragmented in the number of areas that he or she needs to cover and doesn't have specific expertise in public health law. That's what's needed. In Utah, by law the county attorney is the attorney for the health departments, and we are consistently very low in their priority if we rank at all. And in a number of the legal issues that we have, we throw up our hands and struggle a lot, but again financially I'm not sure how you could afford to do it with our budgets.**

**Mr. Ted Pratt**

**Iím just making a very brief observation that as a former selectman standing up in front of town meetings, it was very nice often not to have our town counsel there because we were not forced to live with a legally binding opinion that would be made on the spot. So one of the ways of learning how to use a lawyer is when to have legal counsel present at a hearing or a meeting, and when not to, because you may find yourself bound by a decision you didn't want to hear.**

**Mr. Brumagin**

**I'll just emphasize what Ted said. We have a situation in our county where a businessman involved in landfill in another part of the state didn't have the best reputation. He owned a**

**farm in Holmes County and somebody observed him digging holes out in the field. Everybody was sure he was burying hazardous waste there, and the community was in an uproar. The board of health said "well, we'll hold a hearing in the community to listen to people's evidence and so forth." And our prosecuting attorney, who was our legal counsel, came and attended, and his recommendation during the hearing was that we investigate and dig up all those holes that was a total blow to us. We had the EPA guys in their moon suits and we went out in the field and we excavated each of those holes and didn't find a thing. That was an occasion that I wish the prosecuting attorney wouldn't have been there.**

**Question**

**I'm from New York City, and I'm a member of the board of health, and our board of health, according to the public health law of New York State, the administrative code of the county and the county charter, says that we could make in the sanitary code rules about tobacco smoking in restaurants. A county attorney was invited to our board meeting, and he advised against it. Well we had this article 26 all written up and everything, and we said, "Well, we're going to fight it." So we did go to court, and the judge allowed us to get another lawyer and we went to court and the state judge ruled against us. We asked if we could appeal, and the county attorney wouldn't allow us to do that. What recourse would we have now? Each one of us was sued, but I mean, on the board. We have a nine-member board.**

**Mr. Jacobson**

**I don't see any reason why you can't go out and get your own attorney to represent you, but it would depend on what the code says.**

**Funding for an outside attorney could be a problem, but I do think that Ted's comment in this needs some further clarification. A lot of what has to happen in the interaction between, between the attorney and the local board of health has to occur before the meetings. The purpose of having the attorney is to anticipate what the legal issues are. If you're simply inviting the attorney to show up and render off-the-cuff opinions, you're asking for trouble. That's not how the interaction should go. You have to understand what actions you want to take, what are the issues are on the agenda. That's why in the matrix I put up on the screen, understanding the legal issues means working them out ahead of time so that you're not blind-sided. It may be that the legal advice in both cases was unavoidable, but it should be clarified before you go to the meeting so you have a response ready. In terms of how can you appeal, it becomes very complicated on who has the authority to do it. If you look at the federal department of justice versus the agencies, often times the Department of Health and Human Services might want to appeal, but they have to go through the Department of Justice. The question is are you required to go through a certain line of authority. If you have to go through the county's attorney then**

**probably there's not much you can do other than appealing on the political grounds to the solicitor of the county and saying you want to appeal.**

**Mr. Boutin**

**I just wanted to add a couple of things. I think you're right that politics are really often the issue as opposed to the law. In many states, and I'll use Massachusetts as the example, the legal counsel serves the municipality or the county as opposed to the board of health, and as a result the municipality or county has the final control. So they actually get to make that decision as to whether or not to appeal. They also get to control the purse strings in many cases and the ability to pay the attorney. I know in Massachusetts, like most states, the board of health does not have the option to hire independent counsel unless the municipality approves it first. So you are generally and entirely beholden to the municipality or the county for your legal counsel. I'm actually familiar with the case you mentioned. It was decided on a very bizarre administrative law issue that was perpetrated by the tobacco industry. The industry has used the same argument in a couple of other states and in two other states they were successful. They brought the same argument to Massachusetts last year, and they lost in our Supreme Court. So there is precedent now in other states that says that that line of reasoning is wrong. So we've got a battle between different states as to how that works, but in my opinion that was a bad decision that you got on the law, but you were out-financed by the tobacco industry.**

**Question**

**Just one quick question following up on the lady before me. Have board of health members been sued individually for their official decisions? Is that a potential threat in the future?**

**Mr. Boutin**

**It's an interesting issue. In most states you cannot be individually sued, and generally when you are individually sued, it can be removed off the court case fairly easily with a single action. In Massachusetts the only time a board of health member can be personally liable is if they intentionally do something to harm somebody. For example, I generally give is you're at a hearing and you have an obnoxious person who is arguing with the board of health. They're being very obstinate and rude, and finally you get up, you say "I've had enough" and "pow" you knock them in the face and you knock them down. You're going to have some personal liability there.**

**You can't do that. Obviously you've got personal liability for an individual act like that. The other example in Massachusetts, it's up in the air and we don't have clear guidance on it yet, is whether someone can sue you on the grounds of alleged discrimination. In most states personal liability is limited to intentional conduct. Otherwise it is the municipality or**

**the county that has liability as opposed to the individual. So it's kind of a red herring and an intimidation factor that you do see, but by and large for the most part you do not have individual liability.**

**Dr. Mullet**

**Any additional questions? If not, I would like to thank Peter, Marc, Glen and David for their fine presentations. And thanks to each of you in the audience for being with us here today.**